		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0009241

Facility Name: GOOD SAMARITAN HOME-FLANAGAN

Address: 205 N. ADAMS (Number) FLANAGAN (City) 61740 (Zip Code)

County: LIVINGSTON

Telephone Number: 8157962288 **Fax #** 8157962280

IDPA ID Number: 376052304

Date of Initial License for Current Owners: 120168

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: RICHARD PHILLIPS, CPA **Telephone Number:** 815-842-2138

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01012002 to 12312002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) VELMA LOEWEN
(Title) ADMINISTRATOR

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) RICHARD W PHILLIPS, CPA, CERTIFIED PUBLIC ACCOUNTANT
(Firm Name & Address) RICHARD W PHILLIPS, CPA, 305 W WASHINGTON, PONTIAC, IL 61764
(Telephone) 815-842-2138 Fax # 815-844-1943

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 Report Period Beginning: 01012002 Ending: 12312002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	60	Skilled (SNF)	60	21,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,176	13,935		20,111	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,176	13,935		20,111	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.83%

D. How many bed-hold days during this year were paid by Public Aid?
12 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
PEACE MEALS

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 12/01/68

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 Report Period Beginning: 01012002 Ending: 12312002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	192,003	15,267	4,945	212,215		212,215		212,215			1
2	Food Purchase		123,114		123,114	(3,110)	120,004	(9,509)	110,495			2
3	Housekeeping	67,920	13,735		81,655		81,655		81,655			3
4	Laundry	37,875	2,603	2,536	43,014		43,014		43,014			4
5	Heat and Other Utilities			91,096	91,096		91,096		91,096			5
6	Maintenance	55,306	23,038	77,101	155,445	(55,202)	100,243	(9,715)	90,528			6
7	Other (specify):*											7
8	**TOTAL General Services**	353,104	177,757	175,678	706,539	(58,312)	648,227	(19,224)	629,003			8
	B. Health Care and Programs											
9	Medical Director					6,000	6,000		6,000			9
10	Nursing and Medical Records	1,072,581	58,863	70,247	1,201,691	(20,886)	1,180,805	(25,895)	1,154,910			10
10a	Therapy					14,040	14,040	(14,040)				10a
11	Activities	118,847	2,693	2,888	124,428		124,428		124,428			11
12	Social Services	17,879	318	2,552	20,749		20,749		20,749			12
13	Nurse Aide Training					846	846		846			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,209,307	61,874	75,687	1,346,868		1,346,868	(39,935)	1,306,933			16
	C. General Administration											
17	Administrative	55,058			55,058		55,058		55,058			17
18	Directors Fees											18
19	Professional Services			24,127	24,127		24,127		24,127			19
20	Dues, Fees, Subscriptions & Promotions			28,947	28,947		28,947	(12,123)	16,824			20
21	Clerical & General Office Expenses	46,054	11,949	10,679	68,682		68,682		68,682			21
22	Employee Benefits & Payroll Taxes			373,449	373,449		373,449		373,449			22
23	Inservice Training & Education											23
24	Travel and Seminar			951	951		951		951			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			5,164	5,164	55,202	60,366		60,366			26
27	Other (specify):*			8,090	8,090		8,090		8,090			27
28	**TOTAL General Administration**	101,112	11,949	451,407	564,468	55,202	619,670	(12,123)	607,547			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,663,523	251,580	702,772	2,617,875	(3,110)	2,614,765	(71,282)	2,543,483			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN #0009241 Report Period Beginning: 01012002 Ending: 12312002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			168,535	168,535	(67,374)	101,161		101,161			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,319	14,319		14,319		14,319			32
33	Real Estate Taxes			48,352	48,352		48,352	(48,352)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			231,206	231,206	(67,374)	163,832	(48,352)	115,480			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops		10,630		10,630		10,630		10,630			40
41	Coffee and Gift Shops					3,110	3,110	(3,110)				41
42	Provider Participation Fee		32,850		32,850		32,850		32,850			42
43	Other (specify):*			53,663	53,663	67,374	121,037	(121,037)				43
44	**TOTAL Special Cost Centers**		43,480	53,663	97,143	70,484	167,627	(124,147)	43,480			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,663,523	295,060	987,641	2,946,224		2,946,224	(243,781)	2,702,443			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 Report Period Beginning: 01012002 Ending: 12312002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,509)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,715)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(12,123)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule 5A	(212,434)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (243,781)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (243,781)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops	X		3,110	2	40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 3,110		47

STATE OF ILLINOIS
GOOD SAMARITAN HOME-FLANAGAN
ID# 0009241
Report Period Beginning: 01012002
Ending: 12312002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	INCONTINENCE INCOME	$ (25,895)	10	1
2	COFFEE AND GIFT SHOPS	(3,110)	41	2
3	THERAPY INCOME	(14,040)	10A	3
4	DUPLEX PROPERTY TAX	(48,352)	33	4
5				5
6	INDEPENDENT & CONGREGATE LIVING	(121,037)	43	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(212,434)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 **Report Period Beginning:** 01012002 **Ending:** 12312002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,509)	0	0	0	0	0	0	0	0	0	0	(9,509)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(9,715)	0	0	0	0	0	0	0	0	0	0	(9,715)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(19,224)	0	0	0	0	0	0	0	0	0	0	(19,224)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(25,895)	0	0	0	0	0	0	0	0	0	0	(25,895)	10
10a	Therapy	(14,040)	0	0	0	0	0	0	0	0	0	0	(14,040)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(39,935)	0	0	0	0	0	0	0	0	0	0	(39,935)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(12,123)	0	0	0	0	0	0	0	0	0	0	(12,123)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(12,123)	0	0	0	0	0	0	0	0	0	0	(12,123)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(71,282)	0	0	0	0	0	0	0	0	0	0	(71,282)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 **Report Period Beginning:** 01012002 **Ending:** 12312002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(48,352)	0	0	0	0	0	0	0	0	0	0	(48,352)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(48,352)	0	0	0	0	0	0	0	0	0	0	(48,352)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(3,110)	0	0	0	0	0	0	0	0	0	0	(3,110)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(121,037)	0	0	0	0	0	0	0	0	0	0	(121,037)	43
44	**TOTAL Special Cost Centers**	(124,147)	0	0	0	0	0	0	0	0	0	0	(124,147)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(243,781)	0	0	0	0	0	0	0	0	0	0	(243,781)	45

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 Report Period Beginning: 01012002 Ending: 12312002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 Report Period Beginning: 01012002 Ending: 12312002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 Report Period Beginning: 01012002 Ending: 12312002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 Report Period Beginning: 01012002 Ending: 12312002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	STATE BANK OF GRAYMONT		X	BUILDING ADDITION		09/20/95	$ 100,000	$ 100,000	8/13/2011	5.1700	$ 5,170	1
2	ST. PETRI CHURCH		X	BUILDING ADDITION		11/01/96	25,000	25,000	11/1/2011	7.0000	1,750	2
3												3
4												4
5												5
	Working Capital											
6	FLANAGAN STATE BANK		X	WORKING CAPITAL		12/2/601	75,000	55,000	12/26/03		5,561	6
7	FLANAGAN STATE BANK		X	WORKING CAPITAL		12/26/02	45,000	45,000	12/26/03		925	7
8	FLANAGAN STATE BANK		X	WORKING CAPITAL		3/3/03	18,000	9,274	3/3/03		913	8
9	TOTAL Facility Related						$ 263,000	$ 234,274			$ 14,319	9
	B. Non-Facility Related*											
10	NONINTEREST LOAN											10
11	FROM RESIDENTS		X	FINANCE DUPLEXES		1981	124,771	23,500				11
12												12
13												13
14	TOTAL Non-Facility Related						$ 124,771	$ 23,500			$	14
15	TOTALS (line 9+line14)						$ 387,771	$ 257,774			$ 14,319	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 Report Period Beginning: 01012002 Ending: 12312002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$ 45,400	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 46,876	2
3. Under or (over) accrual (line 2 minus line 1).	$ 1,476	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 46,876	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 48,352	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	43,249	8
1998	41,260	9
1999	45,715	10
2000	45,346	11
2001	45,346	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1200.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GOOD SAMARITAN HOME-FLANAGAN COUNTY LIVINGSTON

FACILITY IDPH LICENSE NUMBER 0009241

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	1313222787009	13.15 ACRES	$ 46,876.00	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 46,876.00	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 Report Period Beginning: 01012002 Ending: 12312002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,700 B. General Construction Type: Exterior MASONERY Frame STEEL Number of Stories ONE

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

INDEPENDENT LIVING FACILITY - DUPLEXES AND CONGREGATE LIVING APARTMENTS

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	14 ACRES	1966	$ 22,917	1
2					2
3	TOTALS	#VALUE!		$ 22,917	3

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 Report Period Beginning: 01012002 Ending: 12312002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1968	1968	$ 754,053	$ 18,851	30	$ 25,135	$ 6,284	$ 771,734	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SEWER IMPROVEMENTS			1980	17,408		20			17,408	9
10	STORAGE BUILDING			1980	32,575	1,086	30	1,086		23,982	10
11	STORAGE FIRE SYSTEM			1981	2,612		15			2,612	11
12	SIDEWALK			1982	4,984		15			4,984	12
13	ENTRY ENCLOSURE			1982	1,477		15			1,477	13
14	FIRE SYSTEM			1982	785		15			785	14
15	NEW ROOF			1991	58,000	3,867	15	3,867		42,537	15
16	NEW ROOF			1992	29,770	1,985	15	1,985		21,835	16
17	ELECTRICAL FIRE SYSTEM			1992	12,615	841	15	841		8,760	17
18	PELLA WINDOWS			1992	6,752	338	15	338		3,380	18
19	LAND IMPROVEMENTS			1981	2,349		15			2,349	19
20	ACTIVITY ROOM			1995	257,361	6,434	30	8,579	2,145	62,913	20
21	ACTIVITY ROOM			1996	30,610	765	30	1,020	255	7,140	21
22	REPLACEMENT WINDOWS			1997	29,894	1,495	20	1,495		8,222	22
23	BLACKTOPPING			2000	4,400	293	15	293		734	23
24	PAINTING			2000	5,230	523	10	523		1,438	24
25	STUCCO EXTERIOR			2000	24,660	1,233	20	1,233		2,672	25
26	BATHROOM			2001	68,257	3,413	20	3,413		4,266	26
27	SIGN			2001	718	36	20	36		66	27
28	A/C COMPRESSOR			2001	17,174	1,145	15	1,145		1,431	28
29	CEILING FIREWALLS			2001	64,794	1,620	30	1,620		1,755	29
30	KITCHEN & OFFICE ADDITIONS			2002	779,688	9,746	30	8,663	(1,083)	8,663	30
31	PAINTING			2002	2,680	89	15	164	75	164	31
32	COMPUTERIZED ENTRY			2002	1,629	54	15	100	46	100	32
33	NEW FLOOR SINK			2002	872	22	15	39	17	39	33
34	A/C COMPRESSOR			2002	6,651	222	15	222		222	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 Report Period Beginning: 01012002 Ending: 12312002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,217,998	$ 54,058		$ 61,797	$ 7,739	$ 1,001,668	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 Report Period Beginning: 01012002 Ending: 12312002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 448,633	$ 31,461	$ 31,461	$		$ 242,138	71
72	Current Year Purchases	27,699	923	923			15	72
73	Fully Depreciated Assets	305,395					305,395	73
74								74
75	TOTALS	$ 781,727	$ 32,384	$ 32,384	$		$ 547,548	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	E450 FORD 1998	1998	$ 48,859	$ 6,980	$ 6,980	$		$ 32,573	76
77										77
78										78
79										79
80	TOTALS			$ 48,859	$ 6,980	$ 6,980	$		$ 32,573	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,071,501	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 93,422	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 101,161	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,739	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,581,789	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	CONGREGATE APARTMENTS	$ 1,334,123	$ 33,640	$ 243,446	86
87	DUPLEXES	1,519,716	37,181	442,643	87
88	EQUIPMENT CONGREGATE LIVING	20,095	1,340	9,827	88
89	LAND IMPROVEMENTS	102,163	2,952	72,757	89
90	FULLY DEPRECIATED	28,106		28,106	90
91	TOTALS	$ 3,004,203	$ 75,113	$ 796,779	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 Report Period Beginning: 01012002 Ending: 12312002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 Report Period Beginning: 01012002 Ending: 12312002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[X]
COMMUNITY COLLEGE	[ ]
HOURS PER AIDE	

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[X]
HOURS PER AIDE	

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$ 846	$ 846
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$ 846	$ 846
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 Report Period Beginning: 01012002 Ending: 12312002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 Report Period Beginning: 01012002 Ending: 12312002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12312002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 38,530	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	171,386		3
4	Supply Inventory (priced at COST)	15,732		4
5	Short-Term Investments	658,829		5
6	Prepaid Insurance	27,745		6
7	Other Prepaid Expenses	17,206		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 929,428	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	61,250		11
12	Long-Term Investments			12
13	Land	116,996		13
14	Buildings, at Historical Cost	5,108,508		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	850,681		16
17	Accumulated Depreciation (book methods)	(2,224,605)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,912,830	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,842,258	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 85,316	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	109,274		29
30	Accrued Salaries Payable	59,617		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,721		31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,876		32
33	Accrued Interest Payable			33
34	Deferred Compensation	166,211		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DEFERRED SUPPORT	1,083,435		36
37		1,000		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,568,450	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	148,500		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 148,500	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,716,950	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,125,308	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,842,258	$	48

***(See instructions.)**

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 Report Period Beginning: 01012002 Ending: 12312002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,819,982	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,819,982	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	305,326	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 305,326	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,125,308	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 Report Period Beginning: 01012002 Ending: 12312002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,485,834	1
2	Discounts and Allowances for all Levels	(149,839)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,335,995	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	14,040	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 14,040	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	5,053	12
13	Barber and Beauty Care	10,382	13
14	Non-Patient Meals	9,509	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	28,487	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 53,431	23
	D. Non-Operating Revenue		
24	Contributions	547,919	24
25	Interest and Other Investment Income***	10,408	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 558,327	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS	7,205	28
28a	INDEPENDENT & CONGREGATE LIVING	282,552	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 289,757	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,251,550	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	706,539	31
32	Health Care	1,346,868	32
33	General Administration	564,468	33
	B. Capital Expense		
34	Ownership	231,206	34
	C. Ancillary Expense		
35	Special Cost Centers	97,143	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,946,224	40
41	**Income before Income Taxes (line 30 minus line 40)****	305,326	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 305,326	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 Report Period Beginning: 01012002 Ending: 12312002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,561	1,630	$ 36,679	$ 22.50	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,993	12,846	287,421	22.37	3
4	Licensed Practical Nurses	6,523	7,254	120,292	16.58	4
5	Nurse Aides & Orderlies	56,974	61,266	596,088	9.73	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	775	775	9,209	11.88	8
9	Activity Director	1,872	2,107	21,126	10.03	9
10	Activity Assistants	12,884	13,930	97,321	6.99	10
11	Social Service Workers	1,843	1,990	17,879	8.98	11
12	Dietician					12
13	Food Service Supervisor	1,816	1,924	23,963	12.45	13
14	Head Cook	2,143	2,303	26,952	11.70	14
15	Cook Helpers/Assistants	12,413	13,695	123,439	9.01	15
16	Dishwashers	2,095	2,219	13,430	6.05	16
17	Maintenance Workers	3,692	4,042	60,022	14.85	17
18	Housekeepers	8,086	8,919	76,506	8.58	18
19	Laundry	3,869	4,177	32,719	7.83	19
20	Administrator	1,763	1,928	54,859	28.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,646	1,826	21,163	11.59	23
24	Clerical	3,547	3,914	40,263	10.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	140	140	4,192	29.94	33
34	TOTAL (lines 1 - 33)	135,635	146,885	$ 1,663,523 *	$ 11.33	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	76	$ 5,638	L1	35
36	Medical Director		6,000	L9	36
37	Medical Records Consultant		840	L10	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	33	1,815	L10	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	450	L10	43
44	Activity Consultant	26	2,527	L11	44
45	Social Service Consultant	26	2,527	L12	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	163	$ 19,797		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	328	$ 13,963	L10	50
51	Licensed Practical Nurses	376	14,655	L10	51
52	Nurse Aides	1,662	38,004	L10	52
53	TOTAL (lines 50 - 52)	2,366	$ 66,622		53

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 Report Period Beginning: 01012002 Ending: 12312002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
VELMA LOEWEN	ADMINISTRATOR		$ 55,058
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 55,058

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ROBINSON & CO	AUDITING	$ 9,755
AOH/ACCU MED SERVICE	COMPUTER SUPPORT	5,807
RK DIXON	COMPUTER SUPPORT	8,016
CONNECTING POINT	COMPUTER SERVICES	549
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 24,127

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 24,506
Unemployment Compensation Insurance	17,524
FICA Taxes	121,200
Employee Health Insurance	162,621
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
PENSION	40,913
OTHER	6,685
TOTAL (agree to Schedule V, line 22, col.8)	$ 373,449

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
WELLSPRING	11,074
LSN DUES	5,750
ADVERTISING & PROMOTION	12,123
Less: Public Relations Expense	(3,871)
Non-allowable advertising	(8,252)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,824

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MILEAGE REIMBURSEMENT	816
Seminar Expense	
IAPA	135
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 951

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 Report Period Beginning: 01012002 Ending: 12312002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number GOOD SAMARITAN HOME-FLANAGAN # 0009241 Report Period Beginning: 01012002 Ending: 12312002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LSN DUES, 5750**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **15**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ Line

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **32,850**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **YES** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **YES** Indicate the amount. $ **9,483**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **30%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **RICHARD W PHILLIPS, CPA** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **YES** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees.

GOOD SAMARITAN HOME
RECLASSIFICATIONS
Year Ending 12/31/02

	From Line	Amount	To Line	Amount
Reclassify Gift & Coffee Shop	2	-3110	41	3110
Reclassify Insurance	6	-55202	26	55202
Reclassify Medical Director	10	-6000	9	6000
Reclassify Therapy	10	-14040	10a	14040
Reclassify Nurse Aide Training	10	-846	13	846
Reclassify NonCare Depreciat	30	-67374	43	67374